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ABSTRACT

This final report of the Title I Task Force on School Support Services shows that poor children in America suffer disproportionately from health and nutrition problems. The report explains why ESEA should be used to reduce these problems in Title I schools. The report also examines current health and nutrition support service programs in Title I schools. The remainder and majority of the report discusses what a Title I school health and nutrition program should include and ways in which the Office of Education can persuade and influence local school districts to initiate such programs in more efficient ways. Suggestions include the following: the development of guidance to help Title I personnel design support service programs and secure the benefits of existing government resources; the development and distribution which will describe ways OEO centers could work with schools; the establishment of a health advisory committee; the issuing of a booklet describing ways nutrition education for elementary children can be taught around the school lunch program. (Author/WS)

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FINAL REPORT

TITLE I TASK FORCE ON SCHOOL SUPPORT SERVICES

Our report shows that poor children in America suffer disproportionately from health and nutrition problems. We explain why ESEA funds should be used to reduce these problems in Title I schools. Thirdly, we examine current health and nutrition support service programs in Title I schools. The remainder and majority of the report discusses what a Title I school health and nutrition program should include and ways that OE can persuade and otherwise influence local school districts to initiate such programs in efficient ways.

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HEALTH OF POOR CHILDREN IN AMERICA

Young people in America are materially less healthy than young people in countries of comparable economic development. For nearly every category of disease, death rates for young Americans exceed those for Swedish, English and Welsh youth. (See Appendix I)

The poor in America appear to have particular health problems. Low-income children, those most likely to attend Title I schools, receive significantly less medical attention than children from wealthier families. Children under fifteen from families earning less than $2000 per year receive about half as many immunizations per year as all American children that age. Relative to all children, poor children see doctors about one half as often, see dentists about one quarter as often, have one third as many dental x-rays, and have three times as many teeth extracted. For children from 5 to 14 years old, the table below shows the percentage of selected income groups which have not seen a doctor for various periods of time. As indicated, large percentages of the children from the lowest income families have never seen a doctor. (All data discussed in this paragraph are shown in the enclosed Appendix 1)

% of Children Who Have Seen a Doctor Within Indicated Time Periods

Time Since Last Doctors Visit (5-14yr)	Family Income ($)				
	< 2000	2000-3999	4000-6999	7000-10000	>10000
less than 6 mos.	25.3	33.3	40.2	46.7	54.7
6-11 mos.	12.6	15.5	20.3	21.8	21.5
1 year	15.8	18.3	18.0	16.3	13.1
2-4 years	22.2	18.3	14.5	11.4	7.8
5 or more yrs.	10.5	7.7	4.6	2.7	1.9
Never	11.5	5.1	1.4	0.6	0

Source: National Center for Health Statistics, Series 10, No. 9, USDHEW, May 1964

Health of Poor Children in America (continued)

In addition to medical and dental problems, poor children seem to suffer disproportionately from emotional disturbances. Examinations of large numbers of children in New York City found that 12% of all children examined were suffering from marked or severe psychiatric impairments, whereas 25% of the welfare children examined suffered from such impairments. This probably understates the frequency of these impairments among poor children since many poor families do not qualify for welfare and many others have failed to register. 1/

The National Nutrition Survey is only partially complete. It has already sampled over thirteen thousand children from low income families. The table below shows the extent to which the poor children sampled suffered from two or more nutritional deficiencies. Approximately 80% of pre-school, low-income children in Texas suffered from Vitamin A deficiency, a vitamin essential to proper vision and proper functioning of the lining of brain cells.

Age (years)	% of children with family income below $2000 with two or more nutritional deficiencies
1 to 9	48.5
10 to 12	39.5
13 to 16	54.5

Source: National Nutrition Survey, Dr. Arnold Schaefer

The consequences of inadequate childhood health care for the poor seem to show up early in adulthood. The medical rejection rates of the Selective Service System (military draft authority) are appreciably higher in the poorer states. In 1968 Mississippi rejected one inductee per eleven hundred, while Connecticut only rejected one per five thousand. Further, by virtually all the usual measures of general health, poor adults in the United States are significantly less healthy than all adults. 2/

As the evidence suggests, we can expect poor children to show up at Title I schools with emotional problems, nutritional deficiencies and a history (and future) of inadequate medical and dental care. Perhaps the most vexing aspect of this situation is that most child illness can be detected and permanently corrected or substantially alleviated. (See Sppendix 2)

1. Mid-Town Manhattan Study, Dr. Thomas Langer, New York, 1964
2. Delivery of Health Services to the Poor, USDHEW, 1967

Our Obligation to Correct Health and Nutrition Problems

The causes of educational achievement are varied and elusive. The Coleman Report -- the only comprehensive statistical study in the area -- found that child educational achievement is not significantly related to academic factors such as curriculum, class size, and facilities. Colemen did find that achievement is rather closely related to the student's sense of security and well-being. In terms of Coleman's analysis, well-being and security stem in part from health, emotional stability and freedom from deprivations such as hunger and pain. The implication of Coleman's extensive data base, therefore, is that support (not academic) services are most likely to produce educational achievement, at least for poor children in elementary school. In a demonstration project where reliable data were kept, academic failures did drop significantly after a support service program was started.[3/] We will probably never know the precise causes of education, but the best available evidence suggests that educational payoffs are likely to flow from medical, dental, emotional and nutritional types of support services. We should therefore be building strong support service programs in Title I schools because better health and nutrition are desirable goals in their own right and because correcting these problems is likely to porduce better education achievement.

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3. Wall Street Journal, 25 April 1967, Rural Texas school failures fell 50% over 2 year period following introduction of free lunch program.

CURRENT ADMINISTRATION OF SUPPORT SERVICES UNDER TITLE I

OE has never issued formal guidelines to the states on how to design and rum support services -- medical, dental, psychological, nutritional and clothing services -- under Title I. Our investigations under the aegis of the Title I Task Force indicate that most states do not have a comprehensive support service program and are not attempting to develop one.

Information and Reporting

We have completed a sample survey of Title I coordinators in Pennsylvania. The survey asked for the kinds of data that are being kept on the health and nutrition status of Title I children. Some school districts keep records on child immunization but not on health screening, and vice versa. Some schools run lunch programs but do not record how many meals are being served to Title I children. Specifically, the survey asked whether data are kept on each student in fifteen key areas within immunization, screening, doctor referral and nutrition categories. The average response indicated that records are kept in only five of these fifteen areas. No respondent kept records in more than eleven areas. The fifteen areas -- which correspond very closely to the health reports utilized in Follow-Through and Head Start -- are shown at question 14 in the enclosed questionnaire.

The survey indicated that, where health and nutrition information is collected, it is usually not reported to the Title I coordinators. Ninety-one percent of respondents indicated that health/nutrition data is reported to school principals, but only twenty-seven percent indicated that Title I authorities (coordinators or other) receive such data. Field trips to various California school districts (Los Angeles, Oakland-Alameda County, Sacremento and San Francisco) revealed similar lack of formal data reporting. Although California schools do collect health and nutrition types of information, these data are rarely consolidated into a single report on a regular basis for school officials -- principals, parents' committees, nurses, teachers or Title I coordinators.

With poor access to incomplete data, Title I officials probably have only an intuitive understanding of the health and nutrition problems of their children. Further, without regular status reports it would be very difficult for Title I personnel to know for sure whether health and nutrition problems are intensifying or subsiding. Also, without systematically assembled data valid evaluation of various programs is infeasible. OE guidelines emphasize the importance of regular data collection and reporting and suggest a format for a health/nutrition status report.

Unfamiliarity With Other Available Resources

The survey and field trips surfaced other serious barriers to the development of support service programs under Title I. Many local coordinators are unsure that Title I funds can be used for non-instructional programs. Seventy-three percent of those sampled in Pennsylvania felt that their state should issue a "definite statement in the Title I guidelines on the school's authority to use Title I funds for nutrition, health and mental health programs". OE guidelines to the states could recommend and draft such a "definite statement".

Awareness of state and Federal social service programs varies widely. In the metropolitan areas of California we found rather thorough understanding by Title I officials of government programs available to Title I children. On the other hand in rural Pennsylvania many Title I coordinators simply did not know that particular programs, including Medicaid, exist. Even where local authorities were aware of a program, there was often a general unfamiliarity with how and where to apply for desired services. Seventy-three percent of those interviewed in Pennsylvania indicated a desire for a manual describing how to apply for the various government support services.

Perhaps the best evidence of local familiarity with existing social service programs is the actual use by Title I children of these services. Virtually all Pennsylvania Title I coordinators indicated that in their districts there is no school program to work with Medicaid, Community Health Centers and the Public Health Service. Only one respondent works with a Community Mental Health Center. Less than fifteen percent of those sampled use the breakfast and milk programs, and one half use some form of the lunch program. In California, and to a lesser extent Washington, D. C., there is wider utilization of these services, particularly of Medicaid. However, in all areas available programs could be more fully employed.

OE could prepare materials for distribution by the states or for direct distribution to local officials describing each major Federal support service program. These materials could explain who is eligible and where to apply. Several local coordinators have indicated that a completed sample application would be more useful than additional instructions on how to fill in forms. These materials could explain who is eligible and where to apply. We could describe a sample problem -- for example, a child with anemia and parents of a specified income, etc. An actual Medicaid application could be completed to meet the facts of the sample problem. Similar sample applications could be prepared for all major government programs.

Inadequate Guidance

In response to an OE request to all states, thirty-two states have forwarded copies of the Title I guidelines which were issued to local school districts. We have read and analyzed these guidelines. The extent to which these guidelines deal with support services varies quite substantially. For purposes of comparison we rated each guideline in four areas -- health, nutrition, emotional problems and consideration of non-academic factors in diagnosing learning problems. The ratings were based on a scale of 0 to 2. Complete and clear guidance was scored 2. The scoring was of necessity subjective and relative. Additionally, we rated (on a different basis) the quality of the evaluation program recommended in the guidelines. The results of this analysis are shown in the enclosed appendix. The appendic includes particularly comprehensive and unusually incomplete examples of state guidance on support services.

Out of a possible eight points, only twenty-five percent of the guidelines scored more than five. Slightly more than half the states entirely omitted one or more of the four guidance categories. Five states filed to mention support services altogether. Many of the states which responded to the request for a copy of their guidelines sent other materials which generally discuss Title I goals; this may suggest that some states have no formal guidelines. None of the guidelines that we have received discuss the need for information and reporting systems. Few discuss specific government programs. On balance it seems that state guidelines are generally inadequate. Support services are systematically underplayed, if not ignored. Few readers of these guidelines are likely to get the impression that support services are encouraged by the states.

Summary

Our schools keep incomplete data on the health and nutrition status of their students. The data that are collected are rarely consolidated into regular comprehensive reports. Title I authorities seldom seek out this kind of data in any form. Further, there is some uncertainty among school officials that Title I funds can be used for support services. School officials, even Title I coordinators, are frequently unaware of many available government programs. Where programs are known, school officials are generally unfamiliar with application procedures, potential benefits, and operational requirements. Lastly, most state guidelines do little to alleviate these problems at the local level.

Title I of the ESEA authorizes the Federal government to distribute funds to state education agencies under a poverty-population based formula. State and local authorities decide how to divide Title I funds between instruction

construction, support services and other programs. Since the amount of expenditures is determined by population and income growth, and the mix of expenditures is determined by state and local authorities, OE has no direct control over Title I programs. OE can therefore only influence Title I expenditures in advisory capacitiess such as issuing guidelines, publishing guidance (how-to) manuals on parrticular problems like diagnosing learning problems, issuing joint memorannda from two relevant Federal programs such as Title I and Title XIX, annd distributing materials which describe methods of using Title I funds whhich have worked well in various parts of the country. Administering throough advice is certainly more difficult and probably more frustrating than aadministering by direct control. But aside from a relative handful of projecct grants, OE's impact on Title I must flow from effective persuasion of hunndreds of independent state and local authorities. The paragraphs on the nexxt page and the enclosed materials to which they refer describe ways for OE to use its advisory powers to improve the delivery of support services in Title I schools.

OE should:

- develop comprehensive and detailed guidance to help Title I personnel design support service programs and secure the benefits of existing government services. This guidance can be provided either by including new materials in existing state guidelines or by persuading the states to distribute a separate package of materials discussing the importance of support services and ways to bring such services to Title I children in a systematic manner. (Enclosed are suggested materials for inclusion in existing guidelines and a proposed separate package on support services.)

- draft a joint XIX-I memorandum encouraging wider use of XIX for school children as part of a broad support service program in Title I schools. This draft memorandum will be used as a basis of discussion in meetings between Mr. Wirth and Mr. Newman of SRS. (A first effort at such a draft joint memorandum is enclosed.)

- develop and distribute information for dissemination which will describe ways OEO centers could work with schools in its catchment area (e.g., prototype contract arrangements; training for principals, teachers and nurses about the center and its school health support services; shared staffing patterns; record transfer; local coordination mechanisms, such as, committees and letters; special joint activities in nutrition education, drug abuse education, preventive health education, etc.; school coordinators committee; learning problem diagnosis and treatment).

- establish a health advisory committee for HEW-OE programs to give particular attention to health programs in Title I schools, Head Start and Follow-Through. (This idea is being reviewed with Gertrude Hunter and Dr. Robert Egbert.)

- find out if health and mental health center directors are interested in distributing (and helping pay for) how-to manuals on health care and learning problems diagnosis (This is being done with Tarail and Osser papers)

- arrange with NIMH for joint publication and distribution of materials developed by contractors. (This is being done)

- issue information on funds available for summer feeding. (This is in process)

- issue information on new funding levels, legislative changes, new regulations, etc, for child feeding programs in next school year (This is in process)

- issue a booklet describing ways nutrition education for elementary children can be taught around the school lunch program. (This is in process)

- hold series conferences with state education agencies to promote comprehensive support service programs.

Illustrative Materials on Support Services for Distribution as a Separate Package by States Title I Authorities

Hunger, sickness, emotional disturbance and inadequate clothing are persistent and damaging problems for many Title I children. Title I resources should be used to alleviate these problems both because healthy, adjusted children learn more easily, and because nutrition, health, emotional balance and adequate clothing are, in their own right, worthy objectives for our school programs.

The Federal government and our state governments sponsor (and pay for) several social services, many of which can be used by Title I children. Bringing these services to needy students requires careful efforts by someone at the local level who is familiar with government programs and the needs of the children. This package of materials is designed to help Title I (or other) personnel establish a systematic program for delivering support services to Title I children. The program described below makes full use of existing government programs, and suggest ways that Title I funds should be used to supplement these programs.

Information System

To understand the incidence and magnitude of student problems with health and nutrition, it is essential to collect relevant data on a regular basis. Although school districts usually collect some such data, health and nutrition records are seldom consolidated in a single report. A single document can and should be prepared to show on a regular basis the status of student health and nutrition. Such a report will show where major problems lie. Over time these reports will show where progress is being made and where it is not. Additionally, uniform reporting helps evaluate which school districts and which programs are working and which are not. (This capability for systematic evaluation will also help officials at the state level to review local support service programs.)

The kinds of information that should be collected on Title I students may vary by state. The table below suggests a format for a health/nutrition status report. Reports can be submitted as often as useful. At a minimum, reports should be annual; reporting each school semester is probably better. The reporting form and frequency selected should not be changed often for uniformity facilitates evaluation.

Information System (continued)

Health and Nutrition Status of Children in Title I Schools

Total Number of Children in School _____

	Total Number Children	% of Total
Number of students in Title I school who have been screened within specified time period [1] for:		
Tuberculin	_____	_____
Hemoglobin or Hematocrit	_____	_____
Vision	_____	_____
Hearing	_____	_____
Urinalysis	_____	_____
Number of students who have been immunized with specified time period[2] for:		
Diphtheria, Pertussis, Tetanus	_____	_____
Polio	_____	_____
Measles	_____	_____
Small Pox	_____	_____
Number of students who have:		
Received complete evaluation and treatment of all medical problems discovered[3]	_____	_____
Not been treated for diagnosed illness	_____	_____
Received treatement of acute illnesses and accidents during program	_____	_____
Received complete evaluation, consultation and treatment for any psychological and psychiatric problems discovered	_____	_____
Not been treated for diagnosed psychological/psychiatric problems	_____	_____

1. As discussed below, school officials should meet with local specialists and parents to decide appropriate screening frequency by disease
2. Appropriate immunization frequency by disease
3. Includes children who needed no treatment.

Information System (continued)

	Total Number Children	% of Total
Number of students who have:		
Learning problems	_____	_____
Received diagnosis and treatment (neurological and perceptional) for learning problems	_____	_____
Received dental examinations within past 12 months	_____	_____
Received topical fluoride application within the past 12 months	_____	_____
Received dental prophylaxis (cleaning) with past 12 months	_____	_____
Not received dental treatment for diagnosed illness	_____	_____
Number of students receiving following meals daily:		
Free		
Lunch	_____	_____
Breakfast	_____	_____
Milk Break	_____	_____
Special Dietary Supplement	_____	_____
Subsidized		
Lunch	_____	_____
Breakfast	_____	_____
Milk Break	_____	_____
Special Dietary Supplement	_____	_____
Number of students who have received assistance for clothing problems	_____	_____

Information Reporting

Each school district may wish to issue health and nutrition status reports to various individuals. Likely recipients include parents, school principals, school nurses, Title I coordinators, state health officials, city or county health officials. Teachers may need information on particular students. All individuals who are going to be held responsible for the health and nutritional development of Title I children should receive this information. Reporting should be accurate and prompt. The school fistrict should consider preparing periodic reports which summarize the major problems and trends which the annual data suggests. The reports should also be used to evaluate various programs as well as to measure relative progress between school districts. Using the data for comparisons, evaluation and problem identification will tend to make all involved parties -- parents, teachers, principals and Title I coordinators -- more aware of health and nutritional problems, as well as more anxious to solve those problems.

Planning

A full support service component addresses medical, dental, emotional and clothing problems. To ensure that adequate and appropriate programs are designed for each area, school districts should meet with local health officials including doctors, dentists, psychologists, psychiatrists, and health or other appropriate consultants. With the help of these professionals a program of testing, screening and prevention should be developed. These meetings between school officials and health and nutrition experts should be used to develop a plan for health screenings. Decisions must be made on: the kinds of examinations given, the periodicity of examinations, the facility at which examinations are given, the people who will give examinations, and the means of financing these examinations[1]. Procedures for following up the results of screening should be established. Screening follow-ups should be designed to ensure that every needy child, accompanied by his parent, actually receives any required medical, dental, or other care. To ensure that care is received, telephone calls can be made, written reminders can be mailed, transportation provided and baby sitters secured. Some areas use volunteers to help with these tasks. The kinds and desired periodicity of immunizations should also be planned. Screening and immunization planning should consider the child's age and years in school so that expensive tests are not unnecessarily repeated. Health records should follow the child to his next school.

Similarly, nutrition programs must be discussed with professionals in the local board of health, hospital nutritionists, physicians and parents. School officials should know approximately what their children are eating, what this diet pattern omits, and what sorts of supplementary nutriments are needed to improve the student's diet. Like medical, dental and mental health planning, nutrition planning requires professional assistance.

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1. The experience of the Federal government with Follow Through indicates that comprehensive dental, medical and psychological services such as those outlined above in the section on health status reporting can be provided to all Title I children in a school district at an average annual cost per child of $65, excluding clothing provisions.

Coordinating With Other Programs

The Title I health program should use existing sources of health care in the school and community but, when necessary, should extend, expand, or establish services to insure continuing personal health supervision and follow-up for participating children. There are a number of public assistance programs which can and should be used for Title I children. Bringing the benefits of these programs to needy children requires a working understanding of the relevant Federal, state and philanthropic programs. These programs were created to be used, but they are unlikely to reach Title I children unless concerned individuals at local levels care enough to familiarize themselves with the scope and requirements of these programs. The applications can be elaborate, and approval must sometimes be sought at more than one government office. The following materials summarize the coverage and applicability of the major social services available to Title I children.

Medicaid

Medicaid, or more properly Title XIX of the Social Security Act, is a joint federal/state program which provides, at no cost to the recipient, certain kinds of medical care to qualified individuals. Qualification standards vary by state. Generally, all individuals with family incomes below a certain level (approximately $2,500) will qualify for a wide range of free medical services. In some states some types of care are also available free to individuals whose family income is above the minimum, but whose income is incapable of meeting the costs of needed medical care. The enclosed table summarizes the types of care available under each state's Medicaid program.

Doctors who accept Medicaid patients are registered with the state. Each school district should maintain a list of the Medicaid doctors in its area. Where screening uncovers an illness requiring medical treatment, Title I or other officials should make an appointment with a Medicaid doctor and make sure that transportation and baby sitting are provided to permit child and parent to go to the doctor's office. Additionally, the Title I official should check up to verify that the needed medical treatment was in fact delivered and that the parents received no bills for services covered under Medicaid. Title I personnel should ask why doctors provided any services not covered by Medicaid which school screening did not indicate were needed.

There are two burdens on the school official (Title I or other). He must know what services are available under Title XIX and who is eligible for these services. Secondly, and more importantly, he must have the energy and patience to arrange with parents for these services.

(At this stage in the guidance each state should list the services available under its Medicaid program. A hypothetical but typical child medical problem should be presented, and an actual Medicaid form completed meeting the facts of the example problem. Alternatively, OE can work out examples and applications for all states.)

Community Health Centers

The Federal government, sometimes by itself and sometimes in partnership with local governments or individuals, has developed a network of 495 community based health centers across the United States. These centers provide comprehensive medical care free or at reduced prices to needy individuals. The centers concentrate on somewhat different problems. However, as shown in the table below, the centers can be aggregated in five categories.

Community Health Centers (continued)

Type of Institution	Total Number of Centers Now Operating
OEO Neighborhood Health Centers	49
Indian health facilities	51
HEW Community Health Centers	25
Maternal and Child Health Centers	112
Community Mental Health Centers (operating costs reimbursed)	258

These facilities are designed to serve needy Americans, including Title I children. Local school authorities and Title I coordinators should know which centers are in their districts. (At this point, the state should refer to an appendix which lists all centers in the state by location, explains how to apply for services and describes some center/school programs already underway in the state. Alternatively, OE can prepare such a list for all 50 states) Secondly, school and Title I officials should meet with center officials to set plans for bringing the center's services to Title I children. The centers can screen and treat children as well as run diagnostic/preventive health programs in a systematic way. Further, the health center and the school may be able to develop and run a health education program for children in Title I schools. Title I schools are perhaps the best vehicle for treating the young, poor population. As such, health center officials who are responsible for improving the health of the poor, would most likely be very interested in a systematic Title I school health program in their area.

Public Health Service

The Public Health Service (PHS) of the U. S. Department of Health, Education and Welfare operates in every state. PHS will finance extensive programs for immunizing children against a wide range of diseases including those shown in the model information system presented above. To start a PHS immunization program state governments must present a formal request to PHS in Washington describing what sort of program is contemplated and why such a program is needed. In most circumstances the entire cost of an approved program is absorbed by PHS.

As with Medicaid and health centers the PHS immunization program is designed to serve needy Americans but will not reach Title I children until someone at the local level has the initiative to meet with local health and school officials to design an appropriate immunization program. Preventing disease

is far cheaper and otherwise more desirable than curing disease which has been allowed to develop. Title I coordinators or other officials should be able to secure a comprehensive immunization program for their school at very low, if any, cost.

The National School Lunch Program

Under this legislation, funds are appropriated by the Congress and apportioned to the various state departments of education to be used to reimburse local boards of education for a portion of the food costs they incur in serving lunches to participating schools. All lunches served must meet minimum standards providing from 1/3 to 1/2 of the child's daily nutritional requirements. Local boards of education also receive donated food commodities from surplus stocks and food purchased especially for the schools to assist them in the service of lunches and to keep the price at a nominal level.

In regular lunch programs, that is, programs in schools in average income neighborhoods, that are able to maintain a solvent position and meet their free and reduced price lunch demands, the maximum rate of cash assistance is 9 cents per lunch served. However, the national average rate of reimbursement is only slightly above 4-1/2 cents in such schools. These are known as "Section 4" schools as funds for regular assistance are authorized under Section 4 of the National School Act.

In addition to funds for Section 4 schools, each State has an allocation of Section 11 funds. These are special assistance funds restricted to use in needy schools in bery low income neighborhoods. All of the operating requirements are the same in Section 4 schools and Section 11 schools. The only difference is that the rate of cash reimbursement for Section 11 schools is up to a maximum of 20 cents per lunch served.

To insure as much flexibility as possible in the use of funds, the Department of Agriculture has amended its regulations to allow State departments of education to assign rates across the board at a flat rate for every lunch or to assign one low rate for paid lunches and a higher rate for free lunches. In those schools where combination rates of reimbursement are used, that is, one rate for paid lunches and one rate for free lunches, the free lunch rate may go up to 25 cents per lunch served. The maximum rate for paid lunches is 9 cents per lunch from Section 4 funds as given above.

The Department of Agriculture's regulations on reimbursement are flexible enough to permit the co-mingling of Section 4 and Section 11 funds in

The National School Lunch Program (continued)

the same school in order to reach a maximum number of children in need of free or reduced price lunches. In addition, the regulations are flexible enough to permit states to use their shares of supplemental Section 32 funds provided by the Congress to assist local schools to provide additional free lunches to needy children not now receiving them.

The Special Milk Program

In addition to the National School Lunch Program, all of the State departments of education receive federally appropriated funds to assist local schools to reduce the price of milk served to paying children. In addition, local schools that meet need criteria similar to those set out for Section 11 funds may upon special application receive rates of reimbursement which will enable them to provide milk at no cost to needy children whom they determine are unable to pay the costs of reduced price milk. This program operates in schools participating in the lunch program as well as schools that do not, and in child-care institutions. Milk may be served anytime during the day. It is served in addition to the half pint of milk included in all lunches.

The School Breakfast Program

State departments of education receive Federal assistance to enable them to reimburse local school boards for a portion of the food costs they incur in serving breakfast to children attending schools under their jurisdiction. The School Breakfast Program is oriented to a greater degree to needy schools than is the case of the National School Lunch Program. However, this is only the first priority.

The Non-Food Assistance Program

In addition to funds for food assistance under the lunch program, the breakfast program, the milk program, all State departments of education receive an apportionment of funds that may be used to assist local school boards in the procurement of food preparation and serving equipment. As is the case in the Breakfast Program this program is also oriented toward needy schools. State departments of education may assist local boards with support up to 75 percent of the total cost of equipment needed for food service programs. States may also use the supplemental funds, mentioned above, to supplement funds appropriated for non-food assistance purposes.

Staffing

There are several types of trained personnel that would be useful in designing and running a school support service program. School nurses, physicians, psychologists and health consultants are widely used in Title I schools. Some schools also use Public Health Service nurses, nutritionists, psychiatrists, social workers, education diagnosticians, speech therapists, health aids, and county health personnel. Washington, D. C. is organizing interdisciplinary teams which will visit Title I schools on a regular basis. The teams will consist of physicians, nurses, policemen and social workers. Many school districts have not been using Title I funds to defray the cost of health personnel, although that is permissible.

In planning student screening/treatment schedules and information systems as described above, school and Title I officials should consider the costs and needs for these various types of support service manpower. The appropriate staffing pattern will vary by district and probably change over time. There seems to be, however, some generally desirable characteristics of support service staffs. Since, as discussed above, there are so many federal and other services, any support service staff should ensure that Title I children take full advantage of these programs. This can be done by designating a single individual to familiarize himself with all Federal programs or by assigning responsibility for particular programs to each of several individuals. In any event, each school district's staff should, collectively, know how to use all available support service programs. A small investment in obtaining this capability can bring services worth tens of thousands of dollars to students.

Whatever set of skilled personnel are used, a center of responsibility is usually helpful. Results are most likely where one individual is accountable to parents, school principal and board of education for the progress of the immunization, screening and lunch programs. Unless responsibility (and requisite authority) is assigned, reasons for lack of progress are likely to pass from one staff member to another. Similarly, as part of the general screening/treatment planning discussed above, it is usually wise to assign specific tasks to particular staff members. Clear assignments help ensure that important tasks are completed.

Teaching Environment

Establishing information systems, setting up screening/testing schedules, utilizing federal programs and selecting support services staff are difficult but well defined tasks. Improving the teaching environment presents far less structured problems. The feelings of the teacher and the child about the child's potential for learning usually strongly affect the child's actual achievement. Similarly, the attitudes of parents toward schooling, or at least the child's perception of those attitudes, also seem to affect actual achievement. Wherever possible Title I personnel and, if necessary, Title I funds, should be used to improve parent, teacher and child confidence and interest in the schooling process and its results.

Building confidence and interest is an enormous job. Some school districts have organized Parent Advisory Committees to review school activities. Parents can comment on policy atlernatives before decisions are made, be informed of subsequent decisions, and be appraised of results. This kind of involvement in school administration may make parents feel that they have some control over the education of their children and hence a stake in the school system. Some schools have set up sub-committees of parents to monitor school health and nutrition programs. Such sub-committees could be given the health status report outlined above. These reports would enable parents to more effectively pressure for better health and nutrition results. Distributing health status reports to parents on individual students may also serve a health education purpose.

The success of efforts to improve child, parent and teacher attitudes depends entirely on the imagination and commitment of local authorities. Unlike health and nutrition areas, the Federal government has not thought through and established programs for building confidence and interest in our local school systems, despite theimportance of this problem.

Evaluation

A crucial and final element of a comprehensive support service program is a system for periodically summarizing and evaluating progress. The health/nutrition status reports should play a key role in this process. Additionally, some data on academic achievement such as reading and math scores will facilitate useful evaluation. Achievement data should be collected at the same times as the health/nutrition data to enhance comparability. With these data many important

Evaluation (continued)

relationships can be investigated. The impact of changes in general health and nutrition on achievement should be measured, with consideration for the likely lag between changes in health and nutrition and changes in achievement. Where the data are adequate the impact on achievement of particular health or nutrition changes may be detectable. Similarly the relation between nutrition and health can be estimated. At a minimum the health nutrition reports can be summarized into progress reports which indicate which health and nutrition indices are improving and which are getting worse.

For purposes of comparability, the state may require some measurements or analyses each year of every school district. But each school system should supplement any required reporting with tests and studies considered useful. Local specialists,including physicians, dentists, nutritionists, school officials, and consultants, should participate in designing the evaluation program. All evaluation analysis should be directed at helping school officials understand which programs or which combinations of programs most effectively lead to results, e.g., immunization shots, meals served, screenings, treatments and educational achievement.

APPENDIX I

Age (years)	Family Income ($)				
	<2000	2000-3999	4000-6999	>6999	All
	Number of Patients Discharged from Short Stay Hospitals/000				
<15	47.5	68.9	67.6	66.1	65.3
15-44	16.2	17.4	16.7	13.0	15.4
	Average Length of Stay Per Visit to Short Stay Hospitals (days)				
<15	10.7	8.7	7.2	8.0	
	Average Number of Doctor Visits Per Year				
<15	3.0	3.7	5.0	5.7	
	% of Population With One or More Chronic Conditions				
<15	19.2	19.4	18.8	20.8	
15-44	76.8	68.3	62.3	61.1	

Family Income ($)	% of All Visits >7 Days for Children <15 years of age
below 4000	32.9
4000 and more	14.3

	Hospital Patient Discharge/000		Average Hospital Days/Discharge		Average Post Hospital Convalescent Days	
	Family Income ($)					
Illness (age-years)	<4000	>3999	<4000	>3999	<4000	>3999
Tonsillectomy (6-16)	8.1	15.7	1.7	1.7	8.4	8.1
Appendectomy (<5)	1.5	2.1	7.9	6.3	27.6	19.5

Delivery of Various Health Services to Children Under Fifteen Years of Age Per Year

	Family Income ($)			
	2000	2000-3999	4000-6999	6999
Immunization/000	.2	.3	.4	.5
X-rays/00	14.4	14.8	16.1	19.6
% Seeing Dentist in last 12 months	13	22	36	54
fillings	39.2	53.6	49.0	49.7
extractions	32.0	15.3	14.4	5.1
dental x-ray	7.4	12.3	19.1	37.6

APPENDIX II

CHRONIC HANDICAPPING CONDITIONS IN 18-YEAR-OLDS, AND PROPORTIONS PREVENTABLE OR CORRECTABLE BY THERAPY

Diagnosis	Proportion of 18-Year-Olds Chronically Handicapped 1/	Proportion Preventable or Correctable Through Comprehensive Health Care 2/		Proportion Preventable or Correctable Through Case-Finding and Treatment at Ages 0, 1, 3, 5, and 9
		Up to Age 5	Up to Age 15	
Orthopedic-Musculoskeletal	2.38%	15%	45%	25%
Asthma	0.81	40	75	20
Hernia	0.66	27	81	45
Genito-Urinary	0.35	5	82	78
Rheumatic Heart Disease	0.22	0	78	5
Congenital Heart Disease	0.15	20	35	30
Epilepsy	0.13	55	79	66
Diabetes	0.11	8	64	5
Avitaminosis	0.10	30	54	15
Dental	0.09	28	72	N.A.
Tuberculosis	0.04	45	81	76
Subtotal for Diagnoses Shown	5.04	20	60	30
Total for all Diagnoses (except vision, hearing, and failure to meet anthropometric standards) 3/	12.23			
Eye Problems	0.78	76	85	75
Ear and Mastoid	0.72	47	85	20
Hearing Acuity	0.69	27	50	25
Visual Acuity	0.56	27	29	20
Total for Diagnoses Shown	7.78	30	62	33
Total for all Diagnoses (except failure to meet anthropometric standards) 3/	15.27			

1/ Preliminary data based on rejection rates in special Selective Service examinations of 18-year-old non-college-bound youth (July 1964-December 1965) under the "Conservation of Manpower" program (Source: Dr. Bernard Karpinos, Office of the Surgeon General, Department of the Army).

2/ Rough estimates of the effects of good health care, based on a survey of the medical literature on these leading handicapping conditions. Conditions "corrected" are conditions not handicapping in civilian life.

3/ "Failure to meet anthropometric standards" (underweight, underweight, excluding malnutrition, overweight, overweight) accounted for rejection of an additional 3.17% of these 18-year-olds.

APPENDIX III

ANALYSIS OF STATE TITLE I GUIDELINES

In response to the Office of Education request for copies of State Educational Agency guidelines to Local Educational Agencies on Title I, thirteen states submitted no information at all, three states submitted management review manuals, one state submitted the Office of Education Regulations, one state submitted information on Title I advisory committees, and thirty-two submitted guidelines.

We have reveiwed the thirty-two guidelines which were submitted. Wide variations were found in their recommendations for using Title I funds for nutrition, health and mental health purposes. This review also measured the degree to which local boards were encouraged to look for relationships between academic achievement and eyesight and hearing problems.

The review also assessed the evaluation procedures of each state. All (submitted) guidelines contained clearly defined requests for proposed evaluation procedures. The evaluation proposals were to accompany all applications for Title I funds. In New Jersey, evaluation reports are requested monthly as well as annually. All states require reports at least annually.

The attached table shows, on a 0-2 scale, the relative significance given in the guidelines to local agencies in each of four areas - nutrition, health, mental health and learning problems diagnosis. The number 0-2 indicate the degree to which each of these factors is encouraged in the guidelines. The highest possible score is "eight", which would result from ratings of "two" in each of the four areas. The ratings are, necessarily, judgemental.

The following quotations are examples of statements made in the guidelines. Those states with "0" ratings will not, of course, be quoted since they failed to mention the areas being rated. California was one of the five states which earned an "eight" rating. The excerpts from the California guidelines -- while not as positive as they might be -- are, along with Missouri, Nevada, Tennessee and Arkansas, the most definitive of those reviewed. They show positive encouragement of support services such as nutrition, health and mental health and also indicate the relevance of these factors to academic achievement.

California

"Supportive components must be related to, and designed to support, the basic components. Supportive components shall consist of the following categories: ..... b) auxiliary services such as nutritional, health, counseling and psychological services..."

"In developing the diagnostic profile, school districts should utilize diagnostic instruments that reflect the child's needs including such factors as health problems, as well as academic strengths and weaknesses"

"Because of the high correlation between educational attainment and economic status, the assessment of the particular needs of the economically disadvantaged child is vital to the development of compensatory education programs. When analyzing educational needs, it is essential to recognize the child as an individual and the differences in educational needs"

"...Enhancing student self-image, motivation, improving student health, or raising student aspirational levels are essential to the objectives of raising student achievement..."

Nevada, which also received an "eight" rating, did not make a lengthy statement on any of the areas being evaluated, but did however, make the relatively emphatic statement which follows:

Nevada

"...Need is identified as: Any consistent emotional, mental or psychological deficiency which is lower than that of the student's age or grade group and which can be improved..."

"...Types of special educational deficiencies to be corrected include ... special handicaps, including health, nutrition, vision, speech, hearing and orthopedic handicaps which interfere with normal education development ... lack of equal educational opportunity due to deficiencies in the school program such as ... inadequate school lunch ..."

Arkansas, with an "eight" rating, made a most emphatic statement, particularly regarding what is herein defined as diagnosis.

Arkansas

"...Educational needs of such children may include a) specially designed instruction, b) supplementary and supportive activities

such as counseling and health benefits, or c) personal service such as books, clothing, and food for economically disadvantaged children..."

"Needs for special educational assistance which result from poverty are of prime importance, yet they are too often neglected in Arkansas projects. Such special basic needs as food, textbooks, ey glasses, health care, school clothing, etc., are essential to satisfactory educational achievement for any child and therefore must be met before any economically deprived child should be expected to make suitable progress. Every effort must be made to provide for students these services through other established health and welfare agencies; and then those personal service needs still unmet should be provided at Title I expense.."

"The highest priority will be placed on requests from eligible applicants ...where the following conditions prevail...additional funds are required to maintain personal services (food, clothing, health)..."

"The school year is rapidly drawing to a close. It is possible that non-committed funds are available in the budget of the approved project...it is suggested that consideration be given to the advisability of including some or all of the following items as a means of utilizing non-committed funds...personal service needs for eligible educational deprived children such as health services including eye glasses, hearing aids, clothing, etc..."

To states, Missouri and Kentucky present the most lengthy statements. The attached pages are copies of their statements.

New Mexico did not significantly stress health, mental health or diagnosis, but did have the following comment on nutrition.

New Mexico

"In cooperation with school lunch people...we have assembled ...latest information about school feeding programs. While the funds available for these new feeding programs have increased substantially, they are still not adequate to provide for all the nation's hungry, needy children. Title I funds may still be used for nutrition programs, but plans for such pro-

grams should be carefully coordinated with school lunch programs .. to avoid unnecessary duplication of effort and to assure maximum impact from combinations of these two funding sources..."

"If the LEA determines food services to be among the priorities for its needy children and has obligated all local, state and federal funding, they then can consider reduced priced meals for needy youngsters with LEA Title I monies... we hope the foregoing will be helpful to you, and we urge you to work closely with your State School Lunch Director so that Title I funds and school feeding funds may supplement each other to the advantage of the needy children"

Michigan, with a total rating of "seven", made the comments below -- a significant portion of which is the reference to hearing loss interferring with school work.

Michigan

"The Committee should become aware of the necessity for broadening the knowledge and understanding of those who will be involved in teaching and bringing related services to the educationally deprived children. The group should become aware of the highly probable need for identifying methods of strengthening and improving the ability of teachers to provide for the educational, socio-emotional and health needs of disadvantaged children. The following list may serve as a guide ... 5.) improving personal health and nutrition. In addition to the educational needs of youngsters, the social and/or emotional needs of disadvantaged children should be studied... health needs of disadvantaged children should also be studied ...handicapped dental health problems, uncompensated hearing loss which interferes with school work, uncorrected physical defects, inadequate nutrition, inadequate or insufficient clothing"

The next two quotations, Kansas and Oklahoma, are examples of "one" rated statements, e.g., they mention these services as possible programs but do not specifically encourage them as priorities or relate them in any way to academic achievement.

Kansas

> "...attention should be given to the information available on... welfare and nutrition, physical and mental handicaps and other pertinent information on which the incidence and severity of the needs of children in the project area can be established.. consideration should be given to such children to avoid interruption of needed enriched services including health, nutrition and welfare services..."

Oklahoma

> "Title I funds may be used to expand or improve kindergarten programs in project areas through the provision of teacher aides, lunches, materials, etc...Also the following activities and services are eligible when they are related to an approved project...disturbed or socially maladjusted children...supplemental health and food services..."

Wisconsin, while failing to mention nutrition, did make the brief "one" rated statement below.

Wisconsin

> "In varying degrees and in various combinations, there will be found the need for the following services: cultural enrichment, social adjustment, physical and mental health, experiential activities and academic adjustment... This sharing of objective and subjective views of the child results in a total approach to the education of the child"

Maine not only failed to mention nutrition, health and mental health, but appears to actively discourage these services as is shown in this quotation from the guidelines.

Maine

> "We must first identify the areas of highest concentration of poverty, and then, once having located the school attendance areas forget about the poverty of the children, and concentrate upon developing programs to meet the special educational needs of the educationally deprived children in these school attendance areas."

Many states used comments identical, or similar to, the one below which is an interpretation of OE regulations, and is probably intended to emphasize that Title I funds should supplement, not supplant, other funds. The OE regulation should be re-worded and/or expanded since it probably tends to discourage use of Title I funds for the services being evaluated here since it places the burden of justification and its related"extra effort" on school officials who generally are already understaffed.

> "Services within the jurisdiction of other agencies should not be discontinued or neglected because of the availability of Title I funds. Social, health, nutrition, recreation and welfare services are to be supported by Title I funds only when no other agency can provide them and then only when they are fully justified as being required to meet the needs of educationally deprived children".

ANALYSIS OF STATE TITLE I GUIDELINES

State	Nutrition	Health	Emotional	Diagnosis	Total
Alabama	0	1	0	0	1
Alaska	2	2	2	0	6
Arizona	1	1	1	0	3
Arkansas	2	2	2	2	8
California	2	2	2	2	8
Delaware	1	1	0	0	2
Florida	0	0	0	0	0
Georgia	0	0	0	0	0
Iowa	1	2	1	1	5
Kansas	1	1	1	0	3
Kentucky	2	2	2	0	6
Maine	0	0	0	0	0
Massachusetts	1	1	1	0	3
Michigan	1	2	2	2	7
Missouri	2	2	2	2	8
Montana	1	1	1	0	3
Nevada	2	2	2	2	8
New Hampshire	0	0	0	0	0
New Jersey	0	0	0	0	0

Legend: 0 = no mention at all
1 = modest metion
2 = relatively emphatic

Analysis of State Title I Guidelines (continued)

State	Nutrition	Health	Emotional	Diagnosis	Total
New Mexico	2	1	1	1	5
New York	0	1	1	0	2
Ohio	1	1	1	0	3
Oklahoma	1	1	1	0	3
Oregon	1	1	1	0	3
Pennsylvania	1	1	1	0	3
South Carolina	1	2	2	2	7
South Dakota	2	2	2	1	7
Tennessee	2	2	2	2	8
Vermont	0	2	2	1	5
West Virginia	0	0	0	0	0
Wisconsin	0	1	1	1	3
Wyoming	0	1	1	0	2

Illustrative Statement on Support Services for Inclusion in State Title I Guidelines to Local School Boards

Health

Unmet needs for medical, psychiatric and dental care can severely limit a child's ability to learn. Wherever necessary Title I funds can and should be used to improve the medical and dental health of Title I students. A Title I health component should include:

- Information System - a montly or quarterly report on Title I students indicating 1) the total number of Title I students, 2) the number of Title I students who are innoculated for polio, measles, and DPT, 3) the number of lunches, breakfasts and milk breaks served to Title I children, 4) the number of Title I children who have been screened within the last twelve (twenty-four) months for TB, DPT, anemia, hearing, vision, dental x-ray, parasites, psychological problems and learning disabilities, and 5)the total number of Title I students who completed treatment under a doctor referral.

- Information Reporting - the monthly (or quarterly) information on the health status of children should be promptly reported to the school principal, the local Title I coordinator and the school nurse.

- Planning - a clear plan for medical and dental services which is developed with the assistance of health professionals and details preventive, screening, referral, and treatment procedures.

- Coordination With Other Programs - Title I personnel should work with students and families to take advantage of available health services and to provide a health education program for children and parents.

- Evaluation - Title I personnel should prepare an annual evaluation of the results of the health component of Title I as they relate to the individual child and the goals of the entire project.

The complete health component includes good preventive care, early detection of defects, appropriate and prompt remedial action, and sustained health supervision.

If initial physical examinations reveal that a child has no abnormalities or conditions requiring treatment, the urinalysis and hematocrit are within normal limits, he has satisfactorily passed a hearing and vision test, and all immunizations are up-to-date, the child should be scheduled for repeated tests within two years. At the suggestion of teachers or parents, examinations should be

performed sooner. Where examinations reveal unhealthy conditions, referral and follow-up should be promptly completed.

The Title I health program should use existing sources of health care in the school and community but, when necessary, should extend, expand, or establish services to insure continuing personal health supervision and follow-up for participating children. Title I funds should be used to pay for those parts of the program which cannot be provided or paid for by programs or funds already available in the community. Medical assistance funds are often available through Title XIX "Medicaid" or through public welfare programs. Services are often available through Community Health Centers, Community Mental Health Centers, private clinics, programs for crippled children, local health department programs, school health programs and philanthropy. Project staff should concentrate on helping parents to use such resources. This procedure will not only conserve Title I funds but will provide children and their parents with services which can be used by all members of the family on a regular basis.

To insure that services are effectively carried out, qualified health personnel -- both professional and paraprofessional -- should be involved in the planning and be responsible for the implementation of the health component of the Title I project.

Nutrition and Other (To be done by Pat's staff - "Other" is primarily clothing program)

Joint Memo on: Coordination of Medicaid and Title I Programs

TO: State Medicaid and Title I Coordinators

FROM: U. S. Commissioner of Education and Administrator of Social Rehabilitation Services

Title I of the Elementary and Secondary School Education Act is designed to foster the academic, emotional and personal development of disadvantaged children. Title XIX of the Social Security Act is intended to improve the health of all disadvantaged Americans. These two programs can usefully serve each other.

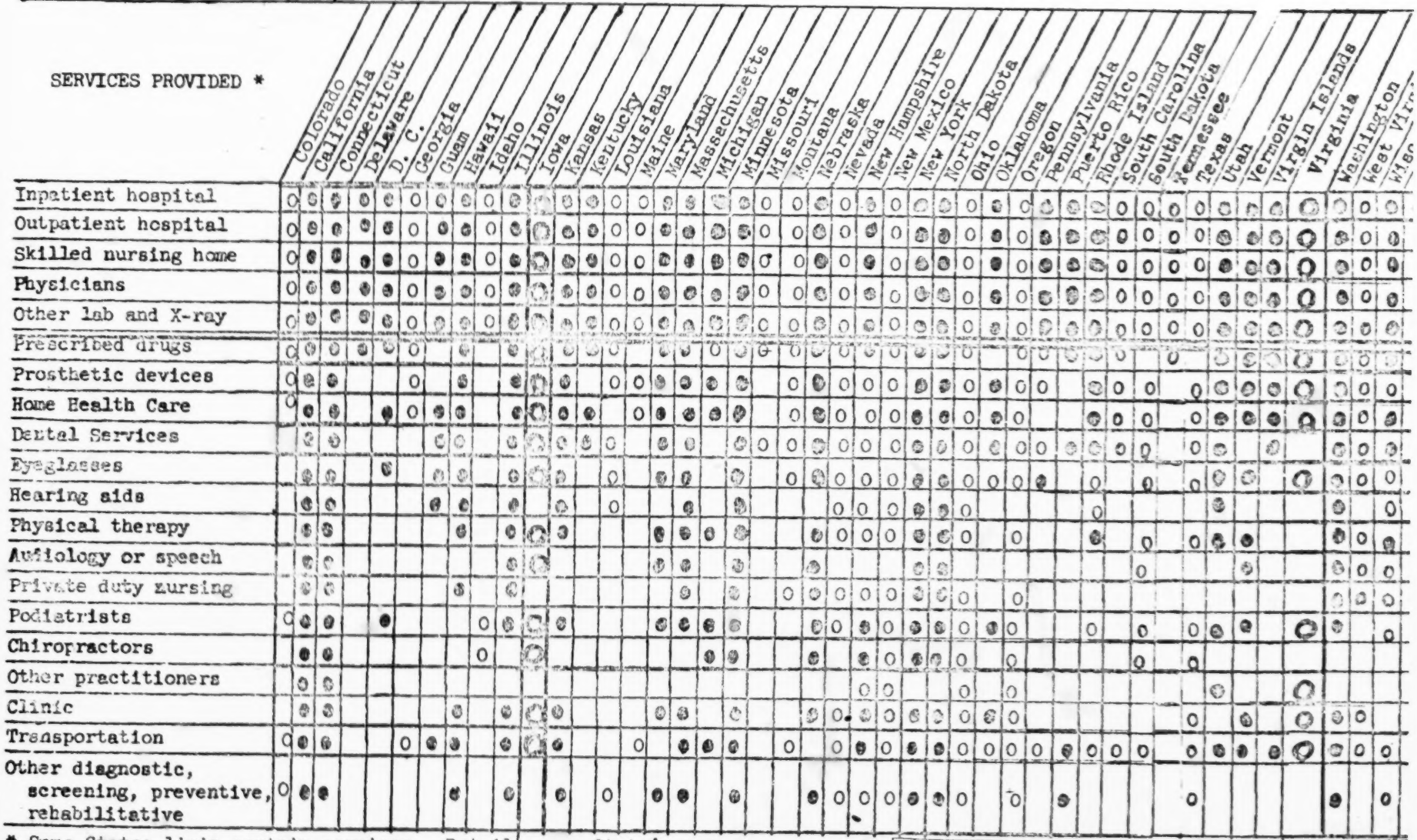
Child development requires comprehensive health care, including preventive diagnostic and therapeutic services. The various state Medicaid programs cover many of these services and can therefore help achieve Title I objectives. Similarly, Title I schools are excellent vehicles for realizing Medicaid goals. Childhood is the best time to correct health problems. Detecting and eliminating chronic disease in childhood is less expensive and far less distressing than treating such disease throughout several years of adult life. Also, building sound health habits and expectations among disadvantaged children, may be the single most powerful remedy to the health problems of the poor in America.

In these ways the Title I and Title XIX programs are potentially reinforcing. To realize this potential we would like state Title I and Title XIX coordinators in each state to meet as often as necessary to set plans for integrating these two programs. We would expect that ultimately each Title I school will have a program for systematically sending children to Medicaid doctors for periodic screening and treatment. In designing such a plan, appropriate medical, dental and psychiatric experts should be consulted. Local education agencies and local Title I coordinators should also be very closely involved. The enclosed document was prepared by the Office of Education for distribution to local Title I coordinators. It discusses the elements of a comprehensive school program for support services. Since health -- medical, dental and emotional -- is a crucial support service, you may find this document useful.

We shall expect a report by September 1 on your plan for bringing Medicaid services to Title I children on a systematic, continuing basis.

MEDICAID: Services offered by the 45 State Medicaid programs in operation 1 October 1969

Legend:
O - Categorically Needy Only
● - Categorically & Medically Needy



* Some States limit certain services. Details on a State's program are available from its social service agency.

Source: Social and Rehabilitation Service
Assistance Payments Administration
Division of Field Services
(adapted October 1969 by WSA PIO)

IF YOU ARE UNABLE TO RETURN THIS QUESTIONNAIRE PERSONALLY, PLEASE MAIL TO:

MR. BRUCE F. CAPUTO
800 FOURTH STREET, S. W., SUITE NB-2
WASHINGTON, D. C. 20024

1. State of school district you work for

Del.	Pa.	N. Y.	N. J.
( )	( )	( )	( )

2. Name of school district _____

3. Indicate best description of the city, town, or area in which your school district is located:

rural ( )

suburban ( )

urban with population:

less than 250,00 ( )
between 250,000 and 1,000,000 ( )
over 1,000,000 ( )

4. Please state your position in the Title I program (local educational) agency coordinator, or other title).

_____

5. Estimate:

- the number of children in your school district: _____
- the number of Title I children in your school district: _____
- the number of elementary schools in your district: _____
- the number of secondary schools in your district: _____
- the amount in dollars in your district Title I programs for
  - school lunch $ _____
  - school breakfast $ _____
  - health
    - personnel salaries $ _____
    - health services $ _____
    - psychological services $ _____
    - pre-school programs $ _____

Total Title I Program $ _____

6. How many Title I target schools are there in your district?

elementary _____

secondary _____

How many were there last year?

elementary _____

secondary _____

7. Are all children in target schools in the Title I program?

Yes ( ) No ( )

8. Who operates the Head Start program in your area?

There is no program ( )
The school district ( )
A private agency ( )
Other ( ): Specify _____

9. If there is a Head Start program estimate the number of children in:

summer program _____

full year program _____

10. Does your school district operate a kindergarten program?

Yes ( ) No ( )

11. Please indicate the box which best describes the use of the following programs for Title I children in the schools in your jurisdiction:

a. Medicaid (Title XIX) (check only one)

1) no school program ( )
2) referrals are made to Title XIX doctors ( )
3) referrals are made to Title XIX doctors, and school nurses follow-up referrals to ensure that needed care is given and parents are reimbursed ( )

If item three was checked, please estimate the number of followed up referrals in your district per month: _____

Question 11 continued

b. Federally funded community health centers (OEO or HEW) (check only one)

1) no center in area ( )
2) no program for coordinating with local center ( )
3) coordinate with local center, make referrals and follow up referrals ( )

If item three was checked, please estimate the number of students referred to health centers per month: _____

c. Federally funded mental health centers (OEO or HEW) (check only one)

1) no center in area ( )
2) no program for coordinating with local center ( )
3) coordinate with local center, make referrals and follow up referrals ( )

If item three was checked, please estimate the number of students referred to mental health centers per month: _____

d. Public Health Service (PHS) (check only one)

1) no involvement ( )
2) have met with local PHS but PHS has no school program ( )
3) meet regularly with PHS; PHS nurses in school; have a PHS immunization program; PHS helps students find doctor care ( )

e. School lunch program for Title I children (indicate % of all Title I children in your district who participate in the following lunch programs)(fill in all entries, including 0%)

1) no school program _____%
2) daily free lunch _____%
3) daily lunch at a reduced price _____%

Question 11 continued

f. School breakfast program for Title I children
(indicate % of all Title I children in your district who participate in the following breakfast programs)(fill in all entries, including 0%)

1) no school program _____%

2) daily free breakfast _____%

3) daily breakfast at a reduced price _____%

12. We are interested in the kinds of student health information your school districts collects. For each category below please indicate (yes or no) whether such data is collected and reported for Title I children.

a. individual record (health and special problems) for each Title I child: Yes ( ) No ( )

b. total number of Title I students innoculated for

measles	Yes ( )	No ( )
DPT	Yes ( )	No ( )
polio	Yes ( )	No ( )

c. total number of Title I students receiving free or reduced price:

lunch	Yes ( )	No ( )
breakfast	Yes ( )	No ( )

d. total number of Title I students who have been screened within the past 12 months for

TB	Yes ( )	No ( )
DPT	Yes ( )	No ( )
anemia	Yes ( )	No ( )
hearing	Yes ( )	No ( )
vision	Yes ( )	No ( )
dental x-ray	Yes ( )	No ( )
parasites	Yes ( )	No ( )
psychological problems	Yes ( )	No ( )
learning disabilities	Yes ( )	No ( )
other	Yes ( )	No ( )

(please explain) _____

_____

(Question 12 continued)

e. total number of Title I students who have been referred to a doctor within the past twelve months

Yes ( ) No ( )

f. total number of doctor referrals that have been completed for Title I children

Yes ( ) No ( )

13. Where health data on students is collected, it is regularly reported to: (check as many as appropriate)

( ) school principal
( ) teacher
( ) school Title I agent (coordinator or other)
( ) official in state government
( ) other health officials. Please specify: _____

14. School programs for nutrition, health and emotional problems can be organized in many ways. For each type of personnel listed below, please indicate 1) whether your school district employs such staff to work with Title I children, and 2) whether Title I helps meet the cost of that staff. (check as many as appropriate)

type of staff	we have such staff working with Title I children	Title I funds help defray the cost of such staff
school nurse	_____	_____
PHS nurse	_____	_____
special personnel in charge of support services	_____	_____
medical doctor	_____	_____
psychiatrist	_____	_____
psychologist	_____	_____

Question 14 continued

type of staff for delivery support services	we have such staff working with Title I children	Title I funds help defray the cost of such staff
social worker	_____	_____
education diagnostician	_____	_____
special therapist	_____	_____
inter-disciplinary team	_____	_____
consultants	_____	_____
health aides	_____	_____
county health personnel	_____	_____
other (please indicate)		
_____	_____	_____
_____	_____	_____
_____	_____	_____

15. Which, if any, of the following do you feel would improve Title I programs for problems of nutrition, health and emotional disturbance? (check as many as appropriate)

a) a definitive statement in state Title I guidelines on

the school's authority to use Title I for nutrition, health, mental health programs ( )
suggested programs in these areas ( )

b) a description by OE Division of Compensatory Education on alternative ways to organize the local and state administration of Title I nutrition, health and mental health programs including an assessment of staffing patterns that have worked well in other parts of the country ( )

c) a model information system for reporting the nutrition, health and emotional balance of students and highlighting problems in a timely fashion ( )

Question 15 continued

d) manuals for Title I personnel and/or teachers explaining

- what Federal programs are available for nutrition, health and emotional problems of students ( )
- how learning problems can be diagnosed ( )
- how nutrition education can be a part of the school lunch program in elementary schools ( )
- how teachers can intervene to alleviate emotional problems and teach disturbed children ( )
- how schools can work with Community Mental Health Centers ( )
- how schools can work with Neighborhood Health Centers ( )

e) a clear statement from HEW Title I and Medicaid officials endorsing expansion of school health programs under these two Federal programs ( )

f) other (please explain)_____

_____

_____

_____

16. Check as many, if any, of the following statements which you feel are accurate.

( ) I feel that more of Title I funds should be used for nutrition, health, and mental health programs.

( ) I feel that more of Title I funds should be used to bring children the benefits of existing programs like Medicaid and school lunch.

( ) I feel it is appropriate to use Title I funds for nutrition, health and mental health programs, but my school district does not feel this way.

( ) I feel it is inappropriate to use any more Title I funds for nutrition, health, and mental health programs.

( ) I feel there is no relation between learning and nutrition, health and mental health problems.

( ) I feel there should be a person in each school district who is responsible for securing the benefits of existing programs such as Medicaid and school lunch for all eligible children.